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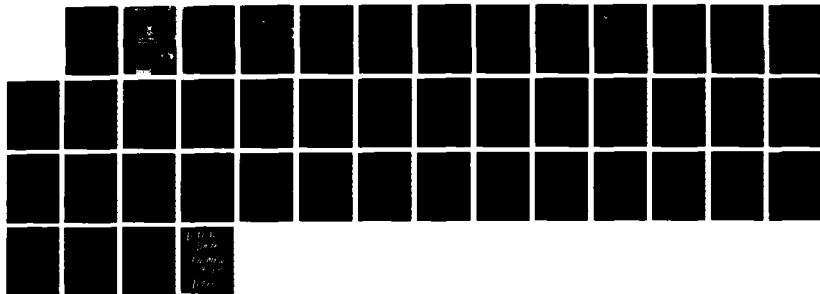
JOB DISSATISFACTION AMONG AIR FORCE CLINICAL NURSES:
CAUSES AND WAYS TO CHANGE IT(U) AIR COMMAND AND STAFF
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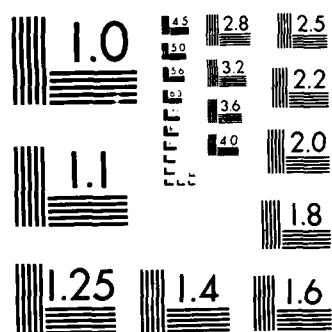
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STUDENT REPORT

JOB DISSATISFACTION AMONG AIR FORCE
CLINICAL NURSES: CAUSES AND WAYS TO
CHANGE IT

MAJOR MARY E. NOVAK

88-2000

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REPORT NUMBER 88-2000

TITLE JOB DISSATISFACTION AMONG AIR FORCE CLINICAL NURSES:
CAUSES AND WAYS TO CHANGE IT

AUTHOR(S) MAJOR MARY E. NOVAK, MAJOR, USAF, NC

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Submitted to the faculty in partial fulfillment of
requirements for graduation.

AIR COMMAND AND STAFF COLLEGE
AIR UNIVERSITY
MAXWELL AFB, AL 36112-5542

AL-H195 243

REPORT DOCUMENTATION PAGE				Form Approved OMB No. 0704-0188	
1a. REPORT SECURITY CLASSIFICATION Unclassified			1b. RESTRICTIVE MARKINGS		
2a. SECURITY CLASSIFICATION AUTHORITY			3. DISTRIBUTION / AVAILABILITY OF REPORT STATEMENT "A" Approved for public release; Distribution is unlimited.		
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE					
4. PERFORMING ORGANIZATION REPORT NUMBER(S) 88-2000			5. MONITORING ORGANIZATION REPORT NUMBER(S)		
6a. NAME OF PERFORMING ORGANIZATION ACSC/EDC		6b. OFFICE SYMBOL (if applicable)	7a. NAME OF MONITORING ORGANIZATION		
6c. ADDRESS (City, State, and ZIP Code) Maxwell AFB AL 36112-5542			7b. ADDRESS (City, State, and ZIP Code)		
8a. NAME OF FUNDING / SPONSORING ORGANIZATION		8b. OFFICE SYMBOL (if applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER		
8c. ADDRESS (City, State, and ZIP Code)			10. SOURCE OF FUNDING NUMBERS		
			PROGRAM ELEMENT NO.	PROJECT NO	TASK NO
					WORK UNIT ACCESSION NO.
11. TITLE (Include Security Classification) Job Dissatisfaction Among Air Force Clinical Nurses: Causes and Ways to Change It					
12. PERSONAL AUTHOR(S) NOVAK, MARY E., Major, USAF, NC					
13a. TYPE OF REPORT		13b. TIME COVERED FROM _____ TO _____		14. DATE OF REPORT (Year, Month, Day)	
				15. PAGE COUNT 30	
16. SUPPLEMENTARY NOTATION					
17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)		
FIELD GROUP SUB-GROUP					
19. ABSTRACT (Continue on reverse if necessary and identify by block number) ➤ Recent unpublished studies indicate job dissatisfaction exists in nurses performing direct patient care on inpatient nursing units. The purpose of this study is to identify possible causes of job dissatisfaction by reviewing job requirements of Air Force clinical inpatient nurses and by analyzing perceptions of inpatient charge nurses and chief nurses. The study concludes there are areas for concern related to job satisfaction on inpatient nursing units in the Air Force. Recommendations on how nurses can improve this situation are offered.					
20. DISTRIBUTION / AVAILABILITY OF ABSTRACT <input type="checkbox"/> UNCLASSIFIED/UNLIMITED <input checked="" type="checkbox"/> SAME AS RPT <input type="checkbox"/> DTIC USERS				21. ABSTRACT SECURITY CLASSIFICATION Unclassified	
22a. NAME OF RESPONSIBLE INDIVIDUAL ACSC/EDC, Maxwell AFB AL 36112-5542			22b. TELEPHONE (Include Area Code) 205-293-2867		22c. OFFICE SYMBOL

PREFACE

During the past several years, increasing numbers of nurses have left their chosen profession because they were dissatisfied with job and work situations. Now, the United States is faced with a critical nursing shortage. Hospitals across the country are frantically searching for ways to improve job satisfaction in order to attract and retain nurses.

The United States Air Force Nurse Corps is not immune to problems concerning job satisfaction in clinical inpatient nursing. Recent studies indicate there are significant problems facing inpatient nurses in the Air Force today--problems that can no longer be ignored.

This project explores issues common to inpatient nurses throughout the Air Force. Most of these problems are not simple, therefore there are no quick and easy solutions to solve them. However, through combining ideas of current charge nurses with personal experiences, some practical suggestions on how nurses can improve clinical nursing in the Air Force are offered in this project.

Studies indicate the current nursing shortage in this country is forecasted to get worse before it gets better. Therefore, now is the time for the Air Force nurse corps to act. We must improve working conditions on inpatient units if we expect to attract and retain top quality nurses required to maintain the high standards of care the military community deserves. More important, our country's medical readiness team cannot afford to be jeopardized by a shortage of qualified active duty nurse officers.

This project does not have all the answers to problems troubling inpatient Air Force nurses today. It merely examines current working conditions on inpatient nursing units, identifies common problems (that could be causing job dissatisfaction), and suggests areas where nurses can begin to improve working conditions on inpatient nursing units in the Air Force.

ACKNOWLEDGMENTS

This enormous project would not have been possible without help and guidance from several key people. First, to Captain Phil Morel of the medical management engineering team-- thanks for the use of the 1987 "Nursing Questionnaires." These proved to be the "backbone" for this project. More important, thanks to all the chief nurses and charge nurses who took time out of their very busy schedules to diligently complete and return these questionnaires. You gave me the fuel and courage I needed to complete this project.

Special thanks to my faculty advisor, Major Jackie Summers. You were always there with feedback and answers I so desperately wanted and needed to hear. You have been a valuable friend and a resource throughout this assignment and I very much appreciate your efforts.

CONTINUED

A few people who are very important in my life deserve special recognition. First, to my sponsor, role model, and mentor - Lieutenant Colonel Maureen Stratton. I am certain I surprised you when I phoned last fall and asked you to sponsor this project. Despite your tremendously heavy work load, you accepted!! I do appreciate that. Also, without your support, guidance, and encouragement, I would not be attending Air Command and Staff College in residence today. This has been a most rewarding, educational assignment for me and I thank you for it! You are an expert nurse manager and I will always value the many lessons I learned from you as my supervisor.

Finally, a very special thanks to my family, especially to my parents. Mom and Dad, you were always there for me when I needed you - no matter where my career in the Air Force took me! Your support, guidance, and understanding, and most important, your love, has made me the nurse and officer I am today.

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ABOUT THE AUTHOR

Major Mary Elizabeth Novak, daughter of Rose Marie and Anthony John Novak was born on 9 December 1954 in Pittsburgh, Pennsylvania. She has four sisters: Jean M. Scholtz, Margaret R., Diane A., and Linda A.; and two brothers: Anthony J. and Robert J.

Major Novak graduated from Washington Hospital School of Nursing, Washington, Pennsylvania in 1974 with a diploma in nursing. She was employed as a staff nurse on a medical-surgical nursing unit at Washington Hospital from July 1974-April 1976. In February 1976, Major Novak accepted a direct commission as a Second Lieutenant in the United States Air Force Nurse Corps. She entered active duty April 1976 and after completing Officers Basic Medical Training at Sheppard AFB, Texas, was assigned to USAF Hospital Holloman, Holloman AFB, New Mexico. There she worked as a staff nurse on the multi-service nursing unit.

Major Novak has vast experience as a staff nurse and charge nurse in medical-surgical nursing. Following her assignment at Holloman AFB, she was stationed at RAF Lakenheath, United Kingdom, where she was a staff nurse on the surgical unit at the regional hospital. In the fall of 1979, she was reassigned to USAF Hospital Wurtsmith, Wurtsmith AFB, Michigan, where she was a staff nurse on the multi-service nursing unit until May 1981. From May 1981-December 1983, Major Novak held the charge nurse position on that unit. Also, during this period, she attended Nursing Service Management in residence at Sheppard AFB, Texas.

In December 1983, Major Novak was reassigned to USAF Medical Center, Wright-Patterson AFB, Ohio where she was both an assistant charge nurse and a charge nurse of a 36-bed Intermediate Surgical Nursing Unit.

Major Novak obtained a Bachelor of Science degree in nursing from the Regents College Degrees program, University of the State of New York in 1986. She is recognized as an expert medical-surgical nurse and is certified as such by the American Nurses Association. She is also a member of the American Nurses Association and the National League of Nursing.

Currently, Major Novak is attending Air Command and Staff College at the Air University, Maxwell AFB, Alabama. In addition, she is actively pursuing a masters degree in personnel management at Troy State University.

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EXECUTIVE SUMMARY



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"insights into tomorrow"

REPORT NUMBER 88-2000

AUTHOR(S) MAJOR MARY E. NOVAK, USAF, NC

TITLE JOB DISSATISFACTION AMONG AIR FORCE CLINICAL NURSES:
CAUSES AND WAYS TO CHANGE IT

I. Purpose: To identify probable causes of job dissatisfaction in Air Force clinical inpatient nursing and offer recommendations on how nurses at all levels can improve working conditions on nursing units in the Air Force.

II. Problem: Clinical inpatient nurses in Air Force health care facilities are currently working long, hard hours, frequently in less than desirable working conditions. Job responsibilities and job expectations of these nurses have noticeably increased over the years. However, manning and staffing of these units have not appreciably changed. The result: clinical nurses are functioning under increased amounts of job related stress that has a negative impact on job satisfaction.

III. Data: Although Air Force clinical inpatient nurses are providing quality patient care (as indicated by Health Service Management Inspection team reports), many Air Force nurses describe symptoms of "burnout" and job dissatisfaction. Middle level nurse managers identified major issues of concern common to inpatient nursing units throughout the Air Force in a recent study conducted by the Air Force Medical Management Engineering Team. The current nurse shortage in this country stimulated researchers and administrators to search for ways to improve job satisfaction in clinical nursing. By reviewing recent published literature, suggestions from nurses in the field today, and personal experiences in

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clinical nursing, recommendations on how to improve clinical inpatient nursing in the Air Force were developed.

IV. Conclusions: Increased demands on clinical inpatient nurses have a negative effect on job satisfaction in Air Force nursing. The nurse corps must improve working conditions on inpatient nursing units if retention of top quality nurses is desired.

V. Recommendations: Nurses at all levels in the Air Force must work closely together and support change in clinical inpatient nursing. Current Air Force regulations need to be examined and either enforced or changed. Ways to reduce job requirements of staff nurses must be studied. The nurse corps, in light of the nationwide nursing shortage, must make job satisfaction of clinical inpatient nurses one of its top concerns.

GLOSSARY

1. Acuity level - way of classifying patients according to amount of nursing care required so the size of nursing staff needed to care for those patients can be estimated accurately.
2. Basic Cardiac Life Support (BCLS) - basic emergency procedure for life support. Consists of artificial respirations and manual external chest compressions to establish effective circulation and ventilation during cardiac arrest to prevent irreversible brain damage.
3. Clinical nurse - a registered professional nurse whose primary area of interest, competence, and professional practice is inpatient nursing in hospitals.
4. Continuing education credit - points awarded by a professional organization for having attended an education program relevant to the goals of the organization. A value is established for the course and that number of points is given.
5. Controlled medications - drugs, regulated under Federal Controlled Substances Act of 1970, that have potential to be abused or misused under certain circumstances by certain patients.
6. Direct patient care - any treatment or educational information a nurse provides to a specific patient.
7. Expert nurse - has an enormous background of experience. Frequently makes clinical judgments or manages complex clinical situations in a truly remarkable way. Provides consultation for other nurses.
8. Holistic care - A system of comprehensive patient care that considers the physical, emotional, social, economic, and spiritual needs of the person.
9. Hyperalimentation - a nutritionally adequate hypertonic solution consisting of glucose, protein, minerals, and vitamins administered through an indwelling catheter into a major artery. Used when feeding by mouth cannot provide adequate amounts of nutrition. Strict asepsis must be maintained as infection is a grave and present danger.
10. Infection control - Identifying, preventing, and controlling disease through adhering to national guidelines set by Center for Disease Control (CDC). Includes formal surveillance monitoring of the environment and nursing practice to ensure compliance with set standards.

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11. Intravenous admixture solution - medication administered either continuously or intermittently through a vein.
12. Job dissatisfaction - an individual's feeling of discontentment and unhappiness with their present employment setting.
13. Job satisfaction - an individual's feeling of contentment and fulfillment with their present job setting.
14. Joint Commission on Accreditation of Hospitals (JCAH) - a private, non-governmental agency that establishes guidelines for the operation of hospitals, conducts accreditation programs and surveys, and encourages attainment of high standards of institutional medical care.
15. Medical center - a large hospital designated by the Surgeon General, USAF, that performs three principal functions: patient service, education, and research.
16. Medical readiness training - mandatory training required for all active duty medical personnel, including nurses, to help prepare medics for wartime medicine.
17. Novice nurse - beginner nurses who have little or no experience of the situations in which they are expected to perform.
18. Nurse intern - novice nurse actively attending the formal Air Force nurse internship program to learn beginner skills required of an Air Force clinical nurse.
19. Nurse intern program - formal program designed to orient and prepare novice nurses to be effective clinical nurses.
20. Nurse preceptor - a clinically experienced nurse, proficient in their skills, who as an additional duty supervises and guides nurse interns through the intern program.
21. Nursing process - an organizational framework for nursing practice, encompassing all the major steps a nurse takes when caring for a patient.
22. Pharmacology - Study of the preparation, properties, uses, and actions of drugs.
23. Primary nursing - Where each nurse works with a group of assigned patients and assumes full 24-hour responsibility for all aspects of their care.

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24. Quality assurance - evaluation of nursing services provided and results achieved as compared to accepted standards.
25. Regional hospital - a medium size hospital designated by the Surgeon General, USAF, staffed and equipped to provide medical and dental care but with a lesser range of specialties than a medical center.
26. Stock medications - medications routinely used on a particular nursing unit authorized by the pharmacy and therapeutics committee to be maintained on that unit for rapid availability.

Chapter One

INTRODUCTION

What It's all About

Currently in the United States there is a nationwide shortage of registered professional nurses impacting delivery of health care in this country. A growing number of nurses are becoming increasingly disillusioned with their careers and are permanently leaving their chosen profession (4:1616). From 1981-1986 professional nurse job vacancy at hospitals doubled to 14%; and although starting salaries for civilian nurse increased 26%, hospitals still are unable to attract nurses (12:60). This shortage is complicated by a significant drop in nursing school enrollment as traditional candidates turn to other career options. It is estimated by year 2000 there will be a deficiency of 619,000 baccalaureate and graduate level nurses (4:1601).

Although overall reported job satisfaction in the Air Force Nurse Corps was rated high (19.89 on a scale of 4 - 28) in an unpublished survey by the corps in 1984 (14:--), more recent studies indicate the degree of job satisfaction in active duty Air Force clinical staff nurses today may not be so high. An independent study performed in 1987 by Anne Manley, Captain, USAF, NC Reserves, on "Relationship Between Reported Time Spent in Direct Patient Care and Level of Job Satisfaction of Selected Air Force Nurse Corps Officers" revealed the more time spent in direct patient care the less satisfied the nurse was in the job (20:61-62). Also, nurses who are low in rank (usually those performing direct patient care) "rated their mental health lower, found their work environment less desirable, and tended to be less satisfied on issues related to working conditions, professional considerations, and emotional climate" (20:55).

The Air Force Medical Management Engineering Team (AF MEDMET) also distributed a nursing manpower questionnaire to charge nurses and chief nurses of facilities with inpatient capabilities throughout the Air Force in 1987. The responses received from this questionnaire indicate there are chronic problems related to staffing shortages, long hours of overtime, and lack of nursing expertise that contribute to increased stress for nurses working on inpatient units.

The 1984 study by the nurse corps indicated overall 76% of nurses across the board were planning on remaining in the Air Force for at least 20 years and 62% of junior officers (first lieutenants - captains) were career oriented. First lieutenants, however, represented the lowest percentile (44%) of nurses planning an

Air Force career (14:--). Recognizing job satisfaction can be a major deciding factor in choosing an Air Force career, this research project will attempt to examine some feelings and perceptions of charge nurses and chief nurses currently assigned to facilities with inpatient capabilities. In addition, possible causes of job dissatisfaction and job-related stress among Air Force clinical nurses will be identified and suggestions on how nurses at all levels can improve working conditions on inpatient units will be offered.

This study's hypothesis is: Air Force clinical nurses are currently functioning under increased amounts of job related stress that has a negative impact on job satisfaction, personal health, and the overall clinical effectiveness of these nurses; and that there exists some practical solutions for all nurses to consider that may improve working conditions for clinical nurses. Due to time constraints, this study is limited strictly to inpatient clinical nursing in the Air Force. This project's sponsor, Maureen Stratton, Lieutenant Colonel, USAF, NC, Medical-Surgical Nurse Coordinator, USAF Medical Center, Wright-Patterson AFB, Ohio, is aware of this project's focus. Also, it is worth noting there are currently other studies related to staffing, manpower, and other concerns of the Air Force Nurse Corps in progress.

Following this introduction, this chapter will include a brief overview of the current situation in inpatient nursing. Chapter 2 examines professional, legal, and military job requirements of clinical inpatient nurses. The views of charge nurses and chief nurses in the field today are discussed in Chapter 3. A literary search for some realistic answers to some very real problems is provided in Chapter 4. Chapter 5 suggests actions for nurses, from the highest level to the lowest level in the Air Force Nurse Corps, to use to lower job-related stress on inpatient nursing units. These actions, if adopted, may promote job satisfaction in nurses performing direct patient care in the Air Force. Chapter 6 ends this project with conclusions, recommendations, and a summary.

OVERVIEW

The Problems

In the USAF, there are 8 designated medical centers, 11 designated regional hospitals, and 76 designated hospitals that comprise the medical treatment facilities (MTF) with inpatient capabilities. In fiscal year 1987, 256,519 patients were admitted to these medical treatment facilities and spent a total of 1,308,738 days as inpatients in these facilities (19:--). Approximately 3,120 general duty clinical nurses (those nurses with Air Force specialty codes (AFSC) of 9751/9756) staff these facilities (18:--). Typically when a clinical nurse is assigned to a medical treatment facility (MTF), the chief nurse of that facility assigns that nurse to a position where they are most needed to support the overall mission of the department of nursing which is "to implement nursing activities that provide for safe, effective well planned care" (13:8-10).

Over the years, the roles and expectations of clinical nurses have significantly grown to meet demands of patient population and standards set by military and civilian agencies. One example of this is quality assurance/risk management programs. To meet expectations set by the Joint Commission on Accreditation of Hospitals (JCAH) and the Health Service Management Inspection (HSMI) teams, individualized, unit-based quality assurance/risk management programs are being incorporated as part of daily living on all inpatient units (1:137-138). The author believes nurses would agree benefits gained from a functioning, meaningful quality assurance program is rewarding to all involved--patients, staff, and institution, however, unit staffing does not increase with this added task and already busy units are taxed even further.

Modern medical technology is also constantly growing and sophisticated state-of-the-art equipment that make medical miracles possible is continuously introduced into the work center for staff nurses to learn, understand, and operate (3:85). Today, nurses are required to be formally certified in operation of certain equipment and in performing certain procedures prior to functioning independently in these areas.

The drug industry is another fast growing industry that continues to keep nurses on their toes. Today, it is literally impossible for nurses to know and remember off the tip of their tongues all the actions, side effects, contraindications, and normal dosages of the multitude of drugs prescribed to inpatients. Currently, staff nurses are being required to pass a medication exam prior to having privileges to administer medications. Also, recognizing the critical importance of administering medications correctly in order to prevent serious, tragic errors, it is imperative up-to-date drug reference books are maintained on each nursing unit and all nurses make a conscious effort to keep up with advances in pharmacology. Patient teaching is another area that has grown over the past years and involves clinical staff nurses significantly. Patients and their families ask more questions and take a greater interest in their health care than ever before. Often, it is the staff nurse who is asked these questions since they are most accessible to the patient.

It must be recognized patients today are likely to be more acutely ill and require more nursing care than ever before. For inpatient units, this means units are probably going to have more patients with higher acuity levels who require more time from the same amount of workers. The emphasis on documentation of patient care cannot be overlooked when discussing the growing responsibilities of clinical nurses. For medical-legal reasons, it is imperative nurses today take documentation of patient progress seriously in order to protect themselves, the institution, and the government from possible legal actions. The author ventures to say any senior nurse officer working in the "field" today would agree being a staff nurse on any inpatient unit today is not the same as it was 10, 5, or even 3 years ago.

Despite the growing role of clinical nurses, manpower and staffing of these units have not been upgraded accordingly. So it should be easy to understand that

although on paperwork, it may look like inpatient nursing units are appropriately staffed, realistically they are probably understaffed (21:--). The growing roles and responsibilities of clinical nurses on inpatient nursing units and lack of manpower to support this task could certainly lead to job dissatisfaction among young nurses. Although manpower studies are scheduled to be performed in calendar year 1988 (21:--), this author does not believe it is wise for nurses to sit back and hope for new manpower standards to solve this apparent problem. The study on job satisfaction by Anne Manley in 1987 already indicates staff nurses are dissatisfied with their current work situation, and responses to the manpower questionnaire from charge nurses that same year indicate there may be some solutions the nurse corps can begin to implement today to improve the situation. Before analyzing these suggestions, however, it is important to review Air Force expectations of a clinical nurse. This, along with the legal and professional obligations of a nurse, will be thoroughly reviewed in Chapter 2.

CHAPTER 2

WHAT IS THE "JOB" OF AN AIR FORCE CLINICAL NURSE?

What precisely does the Air Force expect from a clinical nurse? First, all Air Force nurses must be licensed professional nurses and must maintain an active license in one of the 50 states or territories of the United States. Second, all nurses in the Air Force are required to obtain 30 hours of continuing education credits each fiscal year in topics of education pertinent to their career field. Also, they must be certified in basic cardiopulmonary life support measures. Naturally, as Air Force officers, the Air Force expects nurses to meet standards required of any military officer. This includes pursuing professional military education and educational degrees congruent with rank and responsibility. But what are the unique job responsibilities of clinical nurses?

Air Force Regulation (AFR) 168-4, commonly known as the "bible" to nurse managers, specifically outlines duties of a charge nurse and some duties of a staff nurse on an inpatient nursing unit. Supporting the Joint Commission on Accreditation of Hospitals (JCAH) guidelines, Chapter 7 of this regulation explicitly states the duties of a charge nurse as follows:

- a. Directs, supervises and evaluates nursing activities in patient care.
- b. Provides for continuity of patient care utilizing the nursing process.
- c. Coordinates with other health care providers or departments to facilitate patient care services.
- d. Promotes good interpersonal relationships.
- e. Participates in planning for nursing unit budget.
- f. Provides for and assists in the orientation, education, and training of all unit nursing service personnel.
- g. Evaluates unit nursing service personnel.
- h. Promotes and contributes to environmental safety. (13:7-30)

In addition, AFR 168-4 also designates the "responsibility of maintenance, care, and protection of the health record while it is retained on the nursing unit to the charge nurse if no unit clerk is assigned" (13:7-34). AFR 168-4, in compliance with JCAH standards, also provides specific guidelines for nursing unit inpatient administration from arrival of new patients on the unit to discharging patients from the unit. This includes establishing nursing priorities, assigning the patient a bed, and providing immediate care and treatment as required by the

patient's condition. The nurse is responsible, according to AFR 168-4, for notifying the patient's attending physician of their admission to the unit and if the admissions office has not been notified, also making this notification (13:7-29).

At time of admission, a registered nurse is responsible for obtaining a nursing history or data base from the patient, making an overall assessment of the patient's condition, and initiating an individualized plan of care for that patient as outlined in both AFR 168-4 and JCAH guidelines (13:7-11). Minimal acceptable standards for documenting patient care are spelled out in AFR 168-4. Documentation should be sufficient to "show patient progress and to show nursing care is safe, efficient, and therapeutic. At least one entry is to be made for each acutely ill patient during each tour of duty" (13:7-35). Nurses are also responsible for providing discharge instructions to all patients and documenting in the patient's record the method, either verbal or return demonstration, the patient or patient's family showed that the instructions were understood (13:7-35).

Nurses assume responsibility for all doctors' orders written on AF Form 3066, notes these orders with their signature, communicates these orders to affected members of the health care team, and oversees implementation of those orders. Registered nurses are permitted in emergency situations to accept phone or verbal orders from a physician, but the regulation emphasizes these orders are confined to emergency situations only and must be countersigned by the physician within 24 hours (13:7-35).

Nurses are responsible for administering medications to patients, documenting medications administered, observing effects of medication, and providing patient teaching concerning these medications. AFR 168-4 and JCAH both require the charge nurse to prepare and routinely update the levels of stock medication required for that unit to efficiently operate. Staff nurses are required to routinely check and reorder medications from the pharmacy in order to maintain an adequate supply of needed drugs (13:7-25).

Again supporting JCAH standards, Air Force Regulation 168-4 requires:

... nursing service to set policies to govern nursing service activities, organize nursing committees to facilitate the establishment and attainment of the goals and objectives of nursing service to include committees on nursing service management, nursing practice, and quality assurance, and provide educational training programs for all levels of nursing service personnel. Nursing service also has responsibility for preparing the duty roster time schedule (13:7-32, 8-12).

All military nurses are required to participate in medical readiness training as determined by their medical treatment facility and mobility status. In addition, nurses assigned to teaching facilities may be assigned as nurse preceptors for nurse interns or to orient newly assigned, novice nurses to Air Force nursing.

The legal obligations of a professional clinical nurse must be examined in order to have a complete picture of the job responsibilities of a nurse working on an inpatient unit. The legal aspects of nursing may differ slightly from state to state, as each state has its own nurse practice act outlining precisely what nurses may do in that state. Air Force nurses acknowledge these acts and are aware of the extent of the responsibilities of their civilian peers. Generally, however, in all states, nurses must not perform any act that may be interpreted as the practice of medicine. A nurse's acts, aside from emergency situations, must be performed under direction or supervision of a licensed physician (2:98).

Nurses must legally obey orders of the physician in charge of a patient, unless an order would lead a reasonable person to anticipate injury if it were carried out. However, this does not mean the nurse can go and haphazardly carry out doctors' orders unquestioningly (2:98). For example, if a nurse observes a patient having an adverse reaction to prescribed medication or procedure, it is that nurse's responsibility to exercise their professional nursing judgment, discontinue the treatment, and notify the doctor. Nurses are also liable for their own negligent acts. They can be held personally liable if a patient is injured because of incompetence or carelessness in the performance of their skills or duties. If negligent acts show a wanton and reckless conduct or disregard for human life, such a degree of negligence is considered "gross negligence," which the law views as criminal (2:100). Granted, in the Air Force, a patient would most likely hold the government accountable for any acts performed by a military nurse; however, this does not mean active duty nurses are absolved from their legal obligations to patients or to the nursing profession.

It is only fitting while on the topic of legalities that nurses' responsibilities in documenting patient progress is discussed. Concise and adequate charting of patient progress is one of the largest problems in nursing today (5:100). Prompt, specific charting of significant items concerning patient progress is more important now than ever. Today, threat of lawsuits cannot be taken lightly by any member of the health care team. For nurses to avoid these lawsuits and charges of negligence, nursing documentation must be pertinent and complete.

Thus far, primary responsibilities of a clinical nurse have been outlined. However, this alone is usually not sufficient for a nursing unit to operate smoothly and for nurses to deliver the high quality care the Air Force community has grown accustomed to. Additional duties found in every medical treatment facility must be reviewed. Typically, on each individual nursing unit, the charge nurse and staff nurses will spend many hours developing and maintaining programs; for example: a meaningful staff development education program to maintain the staff's currency in topics pertinent to that unit's function; effective quality assurance program to document compliance with current standards of nursing care; and infection control surveillance and routine monitoring of the environment to ensure current infection control guidelines are upheld. Mandatory monthly staff meetings are usually held on every nursing unit to discuss and resolve issues pertinent to that unit.

In small hospitals, the staff nurse working evenings, nights and weekends will most likely be responsible for providing coverage in the emergency room to readily assist in those emergencies where a nurse is needed. When such an emergency occurs, that nurse still maintains responsibility for patients on their nursing unit, in addition to gaining the added responsibility of the emergency room. Also, these nurses will probably be tasked with pulling "ambulance call" and must be readily available any time, day or night, on off-duty time to provide emergency nursing care during transport of patients whose conditions cannot be managed at smaller facilities. Nurses who specialize in different aspects of nursing, such as obstetrics/gynecology or critical care, may also be subjected to pulling "call" for their respective specialty units if there is a shortage of available experienced nurses or if patient demands require it.

Also, since the charge nurse is not delineated from a staff nurse in manpower standards (21:--), most administrative duties on an inpatient unit are treated like "additional duties" and accomplished after normal duty hours so patient care is not sacrificed. These duties include time schedules, personnel evaluation reports, reviewing and updating operating instructions, and other administrative details required to successfully manage a nursing unit.

Medical readiness requirements and mobility requirements must also not be overlooked, since readiness is the priority medical mission of the Air Force. Chemical warfare training, small arms training, disaster team training, and mock disaster exercises must be accomplished in addition to maintaining a fully operating nursing unit. Since a growing number of nurses are required to fulfill mobility positions, the impact training and mobility exercises can have on an individual nursing unit is becoming more significant.

Inpatient nurses, both at the charge and staff level, must perfect their organizational skills and be able to constantly prioritize and re-prioritize patient care requirements to be effective, efficient clinical nurses. This chapter gave an indication of the various duties clinical nurses must balance to achieve success as an Air Force nurse today. Chapter 3 will reveal perceptions nurse managers have concerning inpatient nursing in today's Air Force.

CHAPTER 3

AT WHAT PRICE QUALITY CARE?

Chapter 2 described the vast duties and responsibilities common to all inpatient clinical nurses in Air Force health care facilities. Two questions immediately come to mind after reviewing these responsibilities. First, are Air Force inpatient nurses providing safe, quality patient care? If so, how and at what price?

Through reviewing overall results of Health Service Management Inspection team reports, a general idea of the quality of nursing care can be obtained. The Health Service Management Inspection (HSMI) is the inspection team of Air Force medical treatment facilities. Routinely, all medical facilities are inspected at least once every two years. Inpatient units must satisfactorily meet objectives and standards outlined in the Joint Commission on Accreditation of Hospitals (JCAH) Manual and Air Force regulations (AFR) to pass this inspection. In other words, Air Force nurses are required to meet both civilian and military standards to receive a favorable report card on a health service management inspection.

The nursing aspect of this inspection is performed by a senior nurse officer who is an expert nurse. During the inspection, inspectors may observe hands-on patient care and talk with staff nurses or medical service specialists. They normally review written operating instructions, patient questionnaires, committee minutes, and compliance with professional educational and certification requirements. At the conclusion of the inspection a rating of outstanding, excellent, satisfactory, minimal, or unsatisfactory is given. These ratings are NOT inflated; so, units receiving a satisfactory rating should NOT be embarrassed since they were obviously in compliance with nationwide standards. It can be reasonably assumed if nursing units receive a satisfactory rating on a health service management inspection, nurses are providing safe, effective care. Units receiving ratings of excellent or outstanding are exceeding standards and are accomplishing mission plus.

The nursing quality assurance portion of the HSMI inspection is a strong indicator of the quality of patient care being provided. The HSMI nursing quality assurance review consists of examining 5 broad categories:

- 1) documentation; 2) nursing practice (skills assessment, patient teaching, nursing rounds, safety, and audits on specific procedures);
- 3) problem identification and resolution; 4) administrative review

(committee reviews and identification of quality assurance items, operating instructions, care and maintenance of equipment, job/position descriptions); 5) education (orientation, licensure verification, and proficiency training) (16:--).

From May 1985-April 1986, sixty medical treatment facilities were inspected by the Health Service Management Inspection team. In nursing quality assurance, 22 facilities (37%) received "excellent" ratings, 35 facilities (58%) received "satisfactory" ratings, and 3 facilities (5%) received marginal ratings. From May-December 1986, 35 facilities were inspected. One facility (2.8%) received an "outstanding" rating, 10 facilities (28.5%) received "excellent" ratings, and 24 facilities (68.5%) received satisfactory ratings in nursing quality assurance. There were no marginal ratings from May-December 1986, and no unsatisfactory ratings were given from May 1985-December 1986 (16:--). Since only 3 out of 95 facilities inspected did not obtain a satisfactory or higher rating in nursing quality assurance from May 1985 to December 1986, it can be reasonably assumed patients are receiving quality nursing care from Air Force clinical nurses on inpatient units.

Air Force clinical nurses are succeeding in their mission, but at what price? Anne Manley's study in 1987 indicated clinical nurses performing direct patient care had a higher degree of job dissatisfaction (20:55). Also, 75% of medical treatment facilities with inpatient capabilities responded to an Air Force Medical Management Engineering Team (AF MEDMET) nursing questionnaire in 1987. Responses to several questions on that questionnaire from charge nurses and chief nurses indicated inpatient nursing is not always a bed of roses and there are some problems requiring further review and attention (17:--).

What exactly are the perceptions of nurses today concerning inpatient nursing? Through reviewing responses to questions in the 1987 Medical Management Engineering Team (AF MEDMET) Nursing Questionnaire, some problems nurses are experiencing today can be appreciated. One question asked is "Does your work center ever work overtime? If so, why, and how much?" (17:--). One hundred percent of respondents answered "yes" to this question. Most charge nurses estimated their staff worked approximately 10-70 hours of overtime a week. Some charge nurses even estimated overtime to be as high as 100 hours a week. Nearly all charge nurses commented they and their noncommissioned officer in charge (NCOIC) took administrative duties home in order to meet patient care demands. That is, charge nurses and NCOICs work as staff nurses and technicians during normal duty hours and fulfill their administrative duties after normal duty hours. Other reasons for working overtime include undermanning of the unit, more patients with higher acuity levels, mission peaks, and decreased number of experienced staff (17:--).

A number of replies indicated physicians performed patient rounds at the same time nurses were attempting to change shifts. With doctors writing new orders, asking questions, and competing for attention from nurses, difficulty in changing shifts exists. As a result, personnel are frequently delayed in going home.

Several nursing units, particularly obstetrics units in small facilities, cited level of nursing expertise as a problem in their work center. Usually, nurses staffing inpatient units are young second lieutenants. In small hospitals, unlike regional hospitals or medical centers, there is a greater possibility of not having senior nurses on evening or night shift to act as resources for the younger staff. Although many nurses have either attended the Air Force nurse intern program or entered active duty with previous civilian nursing experience, it can still take up to a year before a new Air Force nurse is comfortable and proficient with the military system. Also, if a nurse does not have previous experience in obstetrical nursing, it may take a year before becoming proficient in procedures unique to this nursing specialty.

Responses to the MEDMET nursing questionnaire indicate that due to a lack of qualified, experienced obstetrical nurses, nurses with this clinical expertise are frequently "pulling call" and working overtime in order to provide safe care to patients (17:--). Naturally, this places undue strain on experienced nurses. Also, this lack of nursing expertise combined with minimal military knowledge can be overwhelming for many nurses. This not only stresses the individual nurse but also adds strain to the nursing unit as a whole.

Approximately two-thirds of respondents to the MEDMET questionnaire indicated their work centers were not performing their mission without "undue strain." Reasons cited for this stress include "having to do more with less staff," "high patient census and more acutely ill patients," and the "need to work 12 hour shifts because of lack of adequate staffing" (17:--). Charge nurses indicated this decreased unit morale, caused fatigue, and feelings of helplessness in staff members. The increase in additional duties in clinical nursing was also cited as a cause for undue strain in the work place. Additional duties such as committee meetings and training requirements, usually performed on off-duty time, resulted in "no break from the work place" for tired, fatigued nurses. Added responsibilities while on duty also stressed nurses. A response from a nurse at a small hospital indicated the added responsibility for staff nurses to provide emergency room support during evenings, nights, and weekends was sometimes too much when patient requirements were higher than usual on the unit. This caused stress and strain on the work center (17:--).

Recognizing there is obvious stress on nursing units today, it would seem reasonable for nurses not to add to their responsibilities by performing duties that should be performed by another department in the hospital. This, however, is not the case. In the MEDMET Nursing Questionnaire, nurses unanimously answered "yes" to the question, "Is the work center performing locally directed duties that should be performed by another section?" (17:--).

The list of "duties" nurses were performing that should have been performed by another section is long and interesting. Ward clerk duties and administrative duties were the most frequently mentioned items (17:--). Ward clerk duties are numerous and a smooth running nurses station frequently relies on an efficient ward clerk. In addition to putting patients' charts together at admission and taking

them apart at discharge, ward clerks also answer phones, transcribe doctors orders, order forms, update diet requisitions, and make routine distribution rounds. Unfortunately, not all nursing units are afforded the benefits of a ward clerk. Also, ward clerks do not traditionally work evening shifts or weekends. In the absence of a ward clerk, nurses have to absorb these added tasks.

The second most frequent duty nurses were performing that should be performed by another section was obtaining blood for lab studies (17:--). Facilities usually have scheduled times for routine lab rounds when a lab technician comes to nursing units, generally twice a day, and draws blood for lab studies ordered by physicians. If physicians order lab studies between lab rounds, or if physicians deem the lab study is too important to wait for routine rounds, the nurse is often the person who obtains the blood specimen. Most clinical laboratories do not assign technicians to respond to nursing unit requirements 24 hours a day. Unfortunately, lab rounds do not always coincide with patient care requirements. This is particularly true when patients receiving intravenous antibiotics require blood tests to ensure an adequate dose of medication is being administered.

Nurses frequently feel "caught in the middle" when they find themselves drawing blood for lab studies. In the patient's interest, nurses perform this added task, but unfortunately they frequently end up doing more than they should. Obviously, not having a laboratory technician available to nursing units 24 hours a day creates problems for already overtaxed nursing units.

In most Air Force medical treatment facilities, the nursing department is sole provider of patient transportation to clinics and ancillary departments such as x-ray, physical therapy, and occupational therapy. Also, nursing unit personnel are tasked with delivering specimens to the laboratory, delivering and picking up medication orders from pharmacy, and delivering x-ray requisitions and retrieving x-ray reports. On busy days, this "transport and delivery" system can have a tremendous impact on nursing units (17:--).

Pharmacy was another section identified where nurses were performing duties they felt were not their responsibility. In the MEDMET nursing questionnaire, nurses commented they were too frequently required to mix intravenous admixture solutions. One nurse commented it was not uncommon for nurses on her unit to "prepare hyperalimentation solutions" (17:--). Also, nurses, particularly in small hospitals, are tasked with dispensing controlled medications for home use to emergency room patients, since the pharmacy department is not an around the clock operation (17:--).

Another big area that has significant impact on nursing units in performing their mission is housekeeping. Charge nurses, especially obstetrics charge nurses, commented that lack of housekeeping support, particularly in cleaning the labor and delivery room, forces the nursing unit staff to perform housekeeping details such as mopping floors and washing equipment (17:--).

Obtaining outpatient and previous inpatient records is another duty frequently performed by nursing unit personnel that should be performed by another section (17:--). Although AFR 168-4 specifically states "outpatient records and if requested, previous inpatient records are to accompany the patient to the nursing unit upon admission" (13:7-6), this rarely happens. Nursing unit personnel usually end up tracking down and obtaining records themselves in order to obtain pertinent information on complicated medical patients. Some inpatient units indicated staff nurses had the additional responsibility of recovering patients from anesthesia when surgery was performed after normal duty hours. Also, respiratory therapy and physical therapy requirements are performed in many facilities by nursing unit personnel after normal duty hours (17:--).

In summary, it seems nursing unit personnel come to the rescue when other departments are experiencing staffing problems or when mission peaks affect the entire hospital and all departments find themselves overwhelmed. By adding all of these "extras" to a nurse's already busy schedule, one can easily understand why nurses are working long hours of overtime and are feeling stressed and fatigued. Unfortunately, there are more obstacles for nurses to overcome in order to accomplish their duties.

The physical environment of a nursing unit can affect the nurses ability to efficiently perform their duties. The MEDMET nursing questionnaire asked nurses, "Are there any physical conditions in the layout of your work center that effect your work?" (17:--). Again, nurses supplied a long list of items that have a negative impact on their ability to perform their job. They identified lack of storage space, no sinks or toilets in patient rooms, inadequate medication preparation rooms, poor lighting, lack of electrical outlets, and lack of emergency power as having a significant impact on their ability to perform the mission (17:--).

Lack of patient telephones also presented a problem (17:--). Usually there is one portable pay phone per nursing unit that is moved from patient room to patient room. On a unit with 20-35 patients, it is not hard to imagine this phone is in high demand. Many times, patients are not able to maneuver the phone to their room and the nursing staff frequently end up moving the phone from room to room. Also, when patient's families are unsuccessful in reaching their loved one on this phone, they call the nurses station in hopes of talking on that line. Interruptions centering around the patient telephone and patient phone calls can be endless. This has a detrimental affect on the staff's ability to efficiently organize and perform their duties.

Charge nurses also listed not having a staff locker room, a report room, a break room, or a staff bathroom as physical drawbacks on nursing units that directly affect the nursing unit's working capability (17:--). Many hospitals do not have in-house dining facilities and nurses are usually not able to leave the hospital for a lunch or dinner break. Therefore, the need for a private spot on the nursing unit for a nurse to take a "break" away from patients, patient's families, and other hospital personnel becomes very important.

Nurses identified many obstacles they must overcome daily to perform their mission. It should not be difficult to understand why dissatisfaction exists among clinical inpatient nurses. It is clear nurses are required to work long, hard hours in sometimes less than desirable working conditions with what seems to be minimal support from other departments in the hospital.

Clinical inpatient nurses are managing to overcome these obstacles and are providing quality nursing care to patients in Air Force medical treatment facilities. The author believes this reflects the high quality of nurses in the Air Force Nurse Corps today. But can the Air Force retain these nurses? Clinical nurses are admitting they are dissatisfied with the current situation on inpatient nursing units (20:56). In addition, 41.2% of nurses participating in Anne Manley's study in 1987 admitted they were "undecided" about an Air Force career (20:55-56).

The current nursing shortage can have tremendous impact on military nursing. Both military and civilian agencies may be competing for the same highly qualified nurses; therefore, it is time for the Air Force Nurse Corps to consider actions on how to improve clinical nursing. Chapter 4 examines published literature on job dissatisfaction and ideas of how clinical nursing can be improved in the Air Force today.

CHAPTER 4

WHAT THE EXPERTS HAVE TO SAY

Job dissatisfaction in nursing is not a new topic. Nurses have voiced many problems in clinical nursing and these problems have literally driven nurses away from the nursing profession permanently. These problems and proposed solutions consequently became a frequent topic in nursing literature. Unfortunately, there are no simple solutions. However, studies have alerted nurses to possible causes and effects of job dissatisfaction. Once a cause can be identified, a solution can be developed. So it is worthwhile to study what has been written on nurse dissatisfaction.

Studies prove there are many different causes for job dissatisfaction in nursing. The most common reasons cited are poor salaries, undesirable work schedules, an environment that does not provide a sense of worth as a member of the health care team, lack of positive professional interaction with physicians, and under emphasis of individualized patient care (6:9). In the MEDMET nursing questionnaire, Air Force nurses mentioned all of those reasons, with the exception of salary, as problem areas in their facilities today.

BURNOUT

Nurse "burnout" also emerged as a new phenomenon and buzz word in the past decade. Burnout is defined as "wearing out, becoming inoperative and exhausted as a result of over work, dissipation, or lack of energy." Frequently, burnout is used to describe a nurse's feelings of frustration and discontent (9:17-18).

The cause of burnout can be divided in 2 categories: personal and structural. Personal causes include personality traits where high personal expectations, the need for approval, and unrealistic ideas eventually clash with reality and result in personal alienation. New graduate nurses moving from academia to full clinical practice must adapt to new demands and reality or they may quickly become candidates for burnout. Also, the stress of being inadequately prepared for specific job responsibilities could steadily erode confidence and leave a person prey to burnout (9:21).

Structural causes of burnout are those that arise from the work environment. Work schedules contribute to burnout, especially when nurses are required to work many days without sufficient time off or when excessively long duty shifts are

common. Also, the quality and quantity of a nurse's actual workload are important factors. Studies show as size and acuity of the caseload increased, burnout became more evident. Past studies indicate "nurses who take care of seriously ill patients and work for long hours at a time were more apt to speak negatively of their patients and had less successful working relationships" (9:21). Burnout is not limited to areas where patients are seriously ill and workload is heavy. It also occurs when the workload consists primarily of boring, repetitive tasks (9:21-22).

Lack of recognition and feedback concerning job performance is thought to add to the risk of burnout. The physical quality of the work environment can contribute to burnout. The professional required to work in antiquated, deteriorating facilities, with obsolete and unsafe equipment, has added potential for burnout (9:22).

Many signs of burnout are directly associated with the nurse's work habits. They may spend shorter time with each patient and diminish the amount of direct physical contact. The nurse may avoid eye contact and remain distant from the patient. Also, professional nurses' attitudes may become progressively rigid. They may adhere strictly to written policies and treat patients inflexibly (9:18).

The affected nurse may begin to experience true physical illnesses. Headaches, extreme fatigue, and changes in eating and sleep habits may occur without the nurse recognizing the cause. As job pressures build, the nurse who is burning out may try to avoid the work situation. They may resort to drugs or alcohol. New evidence concerning burnout indicates these abuses may be part of its complex picture (9:19). The nurse may also respond to burnout by becoming totally involved in work and become distant or "shut off" from any outside social life. Marital problems may lead to divorce. Meanwhile, unmarried nurses lose social contacts and start to live lives of loners (9:19).

In the MEDMET nursing questionnaire, nurses relayed symptoms of personal and structural burnout exist in their facilities (17:--). In Anne Manley's study on the relationship between reported time spent in direct patient care and level of job satisfaction of Air Force nurses, nurses performing direct patient care indicated they were not satisfied in their job situations. Also, in Manley's study, staff nurses tended to rate their mental health lower than nurses not directly performing patient care (20:50-53). The author believes these studies indicate a significant number of Air Force clinical nurses are truly suffering professional burnout.

How is burnout solved? Prevention is the best solution for burnout. Next to prevention, early recognition and prompt intervention is essential. One big problem with burnout is the person experiencing it is often the last to recognize it. Since the affected nurse does not have energy to remedy their situation, nurse managers need to be alert to symptoms and intervene quickly and effectively. Burnout is not a battle that can be fought alone and victims need empathetic support from nurse managers (8:106).

What can nurse managers do to prevent burnout? Judith S. Koveces, R.N. included nine prevention steps in her article "Burnout Doesn't Have to Happen." They are:

1. Provide relief periods so nurses can recover from stressful interactions and situations.
2. Encourage nurses to take longer vacations rather than few days now and then.
3. Require supervisors to take supportive measures - that is to take time to empathize with their staff nurses, to discuss their problems, recognize their needs and set realistic goals with them.
4. Organize peer support groups, but avoid encounter groups which tend to increase stress.
5. Rotate assignments to avoid boredom and to keep nurses moving in and out of more stressful jobs.
6. Assess the kind of help nurses genuinely need and provide realistic assistance wherever possible.
7. Offer continuing education programs that serve a dual purpose: give nurses time away from the stressful job situation and increase their ability to handle the job.
8. Allow for decompression time after work during which nurses are encouraged to ventilate about the day's problems and thus avoid taking them home.
9. Provide opportunities for nurses to learn stress management techniques such as yoga, meditation, jogging, or other exercise (8:106).

OTHER CONSIDERATIONS

A study examining collaborative leadership style and the effect this style had on staff nurses and job satisfaction was published in 1986. The study consisted of staff nurses rating their head nurses' leadership characteristics. Sixty percent of the staff nurses interviewed saw leadership style as a major factor in job satisfaction and job related stress. The study indicated a collaborative leadership style, where all professional nurses have some input in decision making, improved job satisfaction and reduced work-related stress (5:38A-38H).

The relationship between charge nurses and staff nurses no doubt has great influence on job satisfaction. The role middle managers have in job satisfaction should never be underestimated. Charge nurses have responsibility for all aspects of a nursing unit's operation. They are the one person all others turn to when problems arise.

Traditionally, however, the charge nurse has all the responsibilities of a manager, but none of the power required to successfully perform the job. All too frequently, charge nurses find they need approval from the nursing supervisor before even simple changes, such as changes to unit stock medication, can be made.

This lack of power to have available resources, information, and support necessary to do a job well at the middle management level is bad for the organization. In addition to not having authority to get things done, "powerless managers breed a staff of subordinates who discount them as leaders and for that reason are uncooperative" (7:22). Staff nurses need to know their charge nurse has status within an organization and is capable of effectively influencing the system. If the staff perceives their charge nurse as having power, they too will have power by association. This feeling of power is "crucial to their satisfaction with their role in the organization" (7:23).

What personal qualities must a nurse have to be a successful charge nurse? Greater Southeast Community Hospital in Washington D C examined this question when they experienced difficulties retaining qualified nurses in this management position. Three critical attributes were identified: clinical credibility, self-esteem, and self-confidence (7:25). Clinical credibility is the base upon which authority and respect are built. The charge nurse must be clinically credible so staff nurses will feel comfortable expressing any concerns they may have. The charge nurse must have a sound, in-depth knowledge of the nursing process and must be capable of providing quality patient care. A charge nurse's credibility with their staff is gained largely through clinical expertise, not through management (7:25).

Self-esteem is a measure of one's attitude about one's self-image. Self-esteem marks the difference between the charge nurse who personalizes a negative employee comment, and the charge nurse who can put a negative comment in perspective and move on to more important issues. It is self-esteem that allows charge nurses to be trusting rather than resentful and cynical (7:25). Self-confidence permits one to take risks, confront others, and communicate effectively. A self-confident person knows what they can or cannot do. Charge nurses require large amounts of self-confidence if they are to become leaders capable of instituting change (7:25).

When Greater Southeast hospital hired head nurses with these attributes, problems with nurse retention and job dissatisfaction significantly decreased. Head nurses who are enthusiastic and committed promote high unit morale. Physician/nurse relationships improve and overall patient care is benefited (7:25).

Dissatisfaction with work hours is a common complaint in clinical inpatient nursing. Military nurses voice their discontent with having to work long hours of overtime and then having to return to the work environment for mandatory meetings or required military training. Long duty hours with no significant break from the work place definitely contribute to job dissatisfaction and leads to burnout (9:22). So, what can be done to improve duty hours to better satisfy staff nurses? Many nursing units experimented with ten and twelve hour shift rotations in search of an answer to this question. However, many units also resorted to extended shifts because their manning situation did not permit them to provide adequate nurse coverage any other way. The question that remains is "Do extended duty

hours contribute to job satisfaction?"

One study indicated employee turnover for nursing personnel working ten-hour shifts averaged 9 - 10% annually. In contrast, those nurses working 8-hour shifts in the same facility had a 25% turnover rate. The study revealed there was no significant difference in level of job satisfaction between the two groups of nurses. However, nurses who enjoyed working extended hour shifts generally worked weekends when there is usually less administrative tasks and more patient oriented tasks to be completed by nurses (11:49-52).

Are there any hospitals where nurses are happy and satisfied with their jobs? If there are, what secrets do these organizations have to attract and retain nurses? The answer is yes - there are hospitals where unique methods of managing and delivering patient care are producing positive results in quality of patient care and in nurse retention.

At Beth Israel Hospital in Boston, nurses practice primary nursing. Primary nursing is not a new concept of patient care. But at this facility where registered nurse vacancy is 2% compared to a national average of 13 -14%, there are noted administrative differences. For example, no administrative decisions are made that would alter continuity of patient care. Changes are not made in staffing patterns or in schedules. Nurses are not asked to do more than 50% shift rotation and are not asked to work more than every other weekend. The staff nurses at Beth Israel in Boston are given skills, ability, and support to solve problems. Personnel at all levels work as peers and many changes made come from staff nurses. The result is that the entire health care team now respects the primary nurse (10:34-35).

At Henry Mayo Newhall Memorial Hospital in Valencia, California, a totally new approach was adopted. Since nursing clearly and most directly supports the patient, an environment where all other services help nurses help patients was devised. Housekeeping, dietary, central supply, admitting, respiratory therapy, and to some extent maintenance all report to nursing. Patients believe nurses control everything in the hospital and hold nurses accountable for everything. So with that as a basis, support departments were placed directly under nurses. The end result: Henry Mayo Newhall has no shortage of professional nurses (10:39).

In summary, this chapter examined published literature on professional nurse burnout and searched for ideas on how to improve clinical nursing in the Air Force. Improving job satisfaction in nursing today is a hot topic and civilian hospitals are beginning to use imagination and daring strategies to retain qualified nurse employees.

It is essential the Air Force Nurse Corps examine how clinical nursing can be improved. With the current nurse shortage, the Air Force cannot afford to have a high percentage of dissatisfied nurses who are undecided about a military career. Civilian hospitals are searching for ways to attract and retain nurses, and the Air

Force must do the same. Chapter 5 offers suggestions on how inpatient nursing can be improved to promote job satisfaction in clinical nurses.

CHAPTER 5

SOME SOLUTIONS

Chapter 1 explained the problem and provided an overview of Air Force clinical nursing. Chapter 2 examined clinical nurses' duties and responsibilities. In Chapter 3, current nurse managers offered a more complete picture of what nursing is really like in the Air Force. Ideas gathered from published literature on how civilian counterparts are dealing with job dissatisfaction and improving working conditions can be found in Chapter 4.

So Chapter 5 attempts to answer the bottom line question. What can be done to improve inpatient nursing in Air Force medical treatment facilities? To answer this question, the author offers suggestions derived from clinical experience. In addition, suggestions from chief nurses and charge nurses are provided.

The nursing questionnaire distributed by MEDMET in 1987 included this question, "If you can change anything about your work center, what would you do to improve the way things were done?" (17:--). Charge nurses and chief nurses answered this question with a wide variety of practical ideas. The most frequent suggestion was to hire ward clerks for all nursing units to work both day and evening shifts. This would be a tremendous help to inpatient nurses. It was also suggested formal supervision of ward clerks be changed from medical service corps to nurse corps and charge nurses be made supervisors of these clerks (17:--).

This makes sense since unit charge nurses work with ward clerks and, in reality, supervise ward clerk performance more than medical service corps officers. Being officially in the nursing chain of command, ward clerks are likely to feel a greater "part" of the nursing unit's mission. This will likely improve nursing unit morale and overall delivery of patient care.

Another suggestion from nurses is to develop a "transportation system" to transport patients and specimens (17:--). It is literally awesome the impact transporting patients and specimens has on a busy nursing unit. Suggestions to use Red Cross volunteers or active duty patients awaiting medical board action have been tried in the past; however, these were always temporary solutions. In an era where everyone is watching the budget, civilian hospitals still hire permanent, full-time employees to provide patient transportation. Is this not worth further study in Air Force facilities?

Another logical idea charge nurses offered is to standardize job descriptions,

performance standards, and operating instructions for various size hospitals. Also, forms used in inpatient records should be standardized throughout the Air Force (17:--). This will simplify orientation of newly assigned personnel, promote continuity of patient care, reinforce standards of care, and promote adequate documentation of patient care by eliminating confusion caused by unfamiliar forms. Computers on nursing units could be used to document patient care in addition to ordering supplies, lab work, and making diet changes for patients. Computers could significantly eliminate the paperwork required today to keep a nursing unit functional (17:--).

Another suggestion made by several charge nurses that would not only improve working conditions for unit personnel but also support holistic patient care is to install telephones in every patient room (17:--). Since the military is such a mobile society, telephones are frequently the sole source of communication between patients and families. The stress levels of these patients should not be further taxed by having to depend on one telephone shared by 20-34 other patients. With the current technology in the communication world, why is it not feasible to install individual telephones by each patient's bedside?

Other suggestions offered by charge nurses on how to improve staff morale include obtaining lockers for each staff member and establishing a break area where nursing unit personnel can take a rest from patients, visitors, and other staff members (17:--). Also, offering rewards to young enlisted staff members and junior nurse officers would improve morale and provide a positive incentive to stay in the Air Force. Rewards, however, must be worthwhile. A reserved parking space in the hospital parking lot for nurse and tech of the quarter would be a much appreciated award for a shift worker. Also, three-day passes can be fit into time schedules and are excellent incentives for young staff members.

Obviously, several suggestions offered thus far require coordination, cooperation, and major changes with other departments. The medical service corps currently controls ward clerk positions, and installing computers on nursing units would be a major, costly endeavor. Also, patient telephones would require coordination with several different departments. This does not mean nurses should simply forget these ideas. Instead, nurses should lobby these suggestions and continue to point out the advantages these changes would have on the work center. Chief nurses and command nurses especially must use their positions of power and authority to promote these changes.

What can nurses do to improve working conditions on inpatient units? First, what can staff nurses do? It is vital staff nurses always remember they are members of a team of professional nurses and always conduct themselves as professionals. Nurses must support each other in their words and actions. All decisions made concerning unit management must be supported by all nurses. This creates a strong team, and a strong team is invincible. Nurses who support their co-workers and supervisors will find they are also supported. This professionalism will be a strong incentive and example to enlisted staff members, and respect for nurses will evolve while professionalism among enlisted troops spreads.

Communication is another vital essential on any functioning nursing unit. Staff nurses must communicate with supervisors and subordinates if they expect to be communicated to. Never, never take for granted the charge nurse is aware of every single problem on the nursing unit. If something does not seem quite right, chances are it isn't. Ask questions!

Staff nurses must personally take good care of themselves. Nurses need to be aware they are highly susceptible to stress and burnout. By developing and maintaining healthy habits, nurses will be able to deal more effectively with work-related stress and other predisposing factors of burnout. Staff nurses must also keep periodic tabs on their co-workers. Remember, a nurse suffering burnout is usually unable to recognize the symptoms, and may need help.

Charge nurses have tough jobs. They must be clinical nurse experts, be able to support the administration, support the staff nurses, and be able to effectively communicate with various departments throughout the facility. Charge nurses are used to hearing excuses from other departments as to why patient care cannot be supported, yet are left with the responsibility to see patient care is performed adequately, efficiently, and effectively. In the end, the nurses' role is expanded to extreme proportions and nurses soon find themselves unable to effectively perform their primary duties. When this happens, nurses, particularly charge nurses and chief nurses, need to start looking at ways to lessen the workload for clinical nurses.

One place to start is through enforcing AFR 168-4. As mentioned in an earlier chapter, outpatient and previous inpatient records are suppose to accompany the patient upon admission to the nursing unit. Why, then, is this not being done? Also, AFR 168-4 states "laboratory personnel should collect all specimens from inpatient units and in certain cases, directly from patients" (13:6-6.3d). Yet nursing unit personnel are transporting specimens to the lab in addition to obtaining many blood specimens for the lab.

Also, AFR 168-4 specifically states "verbal orders or telephone orders from physicians are to be confined to emergency situations" (13:7-14[2]). Granted, an emergency can be defined in many different ways depending on the situation; however, ordering lab work to be done the next morning, scheduling diagnostic tests, and "routine" admission orders can hardly be classified as emergency. Yet physicians who get "tied up" in the clinics, or who discover they "forgot" to order something when they were on the nursing unit, will not hesitate to call in phone orders to the nursing unit. Nurses accept these orders and in the process are disrupted in performing their duties. A few of these interruptions can really put a nurse behind on a busy day.

How do nurses stop taking "routine" phone orders? Many people would say "just stop," but it isn't so simple. Nurses need cooperation and support of the entire nursing and medical departments to break this bad habit without creating hard feelings. It is not easy, but solutions to this problem must be found in order to comply with Air Force regulations and to provide the nurse with fewer

interruptions.

The role of medical service specialists on nursing units should be examined. Is it possible to expand this role to decrease the workload of staff nurses? The Specialty Training Standard (STS) for medical service specialists, 902x0, lists collecting blood from venipunctures and initiating peripheral intravenous lines in patients as part of the tasks 3-level and 5-level technicians should be proficient in (15:11). Yet, it is rare to find a medical service specialist on an inpatient unit with these skills. Technicians with these skills can be tremendous assets on inpatient nursing units. Similar to nurses receiving certification in performing venipunctures and initiating intravenous lines, medical services specialists should be required to obtain certification. This certification should be recognized throughout the Air Force in any health care facility. If there are reasons to suspect the technician is not competent in this procedure, they, just like any nurse, should be required to retake the certification class. Permitting our enlisted corps to expand their skills will not only improve morale and decrease workload stress on nurses, but will enhance medical readiness training.

Support from senior nurse officers is very important on a nursing unit. Change is not possible or will not be effective if nurses do not have support from the top. Chief nurses need to be visible to young nurses. Staff nurses need to feel their chief nurse knows and cares about them. Meaningful visits to nursing units where chief nurses have time to informally talk to staff members is one way this can be accomplished.

Finally, communication is the single most important skill to help clinical nurses through these tough times. Nurses must make an honest effort to listen to each other both through verbal and non-verbal communication. Sounds simple, but poor communication is often the underlying cause of most problems, and effective communication is usually the solution to these problems.

This chapter provided ideas that, if implemented, may improve job satisfaction in clinical inpatient nursing. Chapter 6 will summarize and conclude this research project with this author's recommendations on how clinical inpatient nursing in the Air Force could be changed for the better.

CHAPTER 6

CONCLUSION

This research project attempted to prove that Air Force clinical nurses are currently functioning under increased amounts of job-related stress that negatively impact job satisfaction, personal health, and the overall clinical effectiveness of these nurses. Results derived from this study are:

1. Recent studies indicate Air Force clinical nurses providing inpatient care are functioning under greater levels of work-related stress.
2. Job satisfaction in Air Force clinical nurses seems to be negatively affected by this stress.
3. Air Force inpatient charge nurses describe conditions on nursing units ripe for "burnout" syndrome.
4. Reports indicate clinical nurses are providing effective, quality nursing care to patients in Air Force medical treatment facilities.

RECOMMENDATIONS

1. Advocate ward clerks be placed in the nursing chain of command with the charge nurse as the officer in charge of the ward clerk.
2. Advocate ward clerks be hired for all nursing units for both day and evening shifts.
3. Explore feasibility of hiring "transport" system in regional hospitals and medical centers to transport patients and specimens throughout the hospital.
4. Standardize job descriptions, performance standards, and operating instructions for various size hospitals.
5. Standardize forms used in inpatient records throughout the Air Force.

6. Advocate obtaining computers to be used to document patient care and to support unit management.
7. Suggest and urge telephones be installed in every patient room. Cite the positive implications this will have on patient care and nursing manpower.
8. Obtain lockers and provide a "break" area on nursing units for staff use.
9. Develop and support meaningful incentive programs to reward junior nurses and medical service specialists.
10. Prevent burnout by encouraging healthy personal habits and through prompt recognition and early intervention.
11. Enforce or change AFR 168-4. Do not assume responsibility for another section's duties.
12. Certify and permit medical service specialists to perform venipunctures and initiate peripheral intravenous lines.
13. Continue to practice and improve good communication skills.

SUMMARY

Job dissatisfaction in nursing is not unique to civilian nurses. Studies performed in recent years indicate there is a significant number of Air Force clinical nurses who are dissatisfied with their present work situation.

This research project explored reasons for job dissatisfaction in Air Force clinical nursing. Professional and military duty obligations of clinical nurses were reviewed. These obligations have significantly expanded over the past few years and have started to reach unrealistic dimensions. As a result, clinical nurses are falling victim to "burnout" syndrome, which in turn is affecting their job satisfaction.

Air Force clinical inpatient nurses are managing to provide quality nursing care to patients despite adversities. Inspection reports are favorable and nurses are meeting nationally directed standards of patient care. However, there are many different problems for nurses to overcome in order to maintain this standard of care.

Patients are admitted to hospitals for one main purpose--they require nursing care. Nurses performing this care in Air Force health care facilities are screaming change is necessary if they are to deliver the quality of care the military deserves. Change is also necessary if the Air Force Nurse Corps expects to survive the current nationwide nursing shortage crisis. Improvements in Air

Force clinical nursing are possible if all nurses work together advocating change in pursuit of one common goal: maintaining high quality, professional nursing care for all patients in Air Force medical treatment facilities.

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